avoided by using better technique and larger-sized buttons. Or a series of Lembert sutures may be employed to surround the entire area.

In the second series the buttons prevented the passage of the intestinal contents. This is more common in the large intestine, where the contents are solid. It is to be avoided by the use of buttons having a large aperture and the administration of laxatives at a proper time after the operation. He also would not advise its use in connection with the large intestine.

In the third series there was perforation of the intestine either from defective union or by gangrene from later pressure by a button of too large calibre. The defective union in most cases was due to a defective construction of the button. The surfaces should be flat and compress equally, and not cut through on the border of the button. The calibre of the male and female portion of the button should be equal externally, so that they do not overlap each other when in position.

Finally, it is sometimes the case that in a gastro-enterostomy the button is not expelled, but falls into the stomach, where it gives rise to complications.

The author does not believe that these accidents should prevent the use of the button. It has the great advantage of permitting of a rapid operation in patients frequently very feeble and incapable of supporting an operation of longer duration. The efforts of surgeons should be directed toward improving the mechanical construction of the button to make it lighter, less voluminous, and absorbable.

In the discussion following, JOUNESCO said that he had employed the button in a number of instances, and thought that the procedure might be improved by a modification in the technique of its employment.

Instead of passing the button into the stomach or intestine by the usual method, he makes another opening, passes the button through that, and then cuts down upon it where it is pressed outward at the point where he desires it to emerge; thus the opening is not large enough for it to pass through and it is retained in a better position. The first openings are then sutured.

Suture of the Lateral Sinus; Recovery.—SCHWARTZ (*Gaz. Hebdom. de Méd. et de Chir.*, October 22, 1896) reports an interesting case in which, in raising a depressed fracture, caused by the kick of a horse, the dura was found to be adherent to the bone at a point directly over the left lateral sinus; despite all precautions it was torn for about one centimetre. A finger placed over the wound arrested the hemorrhage in a measure while two silk sutures were introduced by a fine Reverdin needle. When the sutures had been tied the blood flowed only by the suture-wounds, and was readily controlled by a small tampon of iodoform-gauze, which was carried out of the wound; the patient recovered. The bone was found to be necrosed at the point where the tear took place, and there was an osteitis which involved the sinus.

The patient remained in the hospital six months, and recovered completely from the mental and motor cerebral symptoms. There remained only some slight defect of memory.

The case shows that suture of the sinuses is possible in spite of their rigid, fibrous character, and should be employed when other means fail. It should be the method of choice in large sinuses, as the lateral sinus and the posterior portion of the superior longitudinal sinus, where permeability is of great value. In other cases catgut tampons or compression may be employed.

Two Cases of Replacement of the Diaphysis of the Tibia by the Diaphysis of the Fibula.—POIRIET (*La Méd. mod.*, November 4, 1896) reports two very interesting cases in which, after the almost total loss of the diaphysis of the tibia by osteomyelitis, he succeeded in replacing that diaphysis by that of the fibula by grafting it into the epiphysis of the former. The fibula became hypertrophied and replaced functionally the tibia.

Appendicitis.—DUPLAY (*La Sem. Méd.*, October 7, 1896), in speaking of the treatment of different forms of appendicitis, says that in an acute attack one should wait for resolution to take place, and then operate during the period between the attacks. If, on the contrary, suppuration takes place, the abscess should be opened immediately. If the appendix is found, it should be ligated at its base and removed. If, however, it is not found in the cavity, shut off by the adhesions and false membranes from the general peritoneal cavity, it should not be sought for; these adhesions should be respected, and one should be content to drain the abscess-cavity by inserting iodoform-gauze.

Acquired Hydronephrosis.—CABOT, after describing some of the causes of this condition (*Boston Medical and Surgical Journal*, vol. cxxxiv., No. 17, 1896), relates a case illustrating one variety which he succeeded in curing by a new method. The patient was a woman, thirty-two years of age, whose symptoms began ten years before the present observation. Two years before the operation she noticed an enlargement in the right side of the abdomen. Pain was constant and increasing in severity. A fluctuating movable tumor was easily made out. On account of the high degree of mobility it was thought unsafe to aspirate from the loin. An abdominal incision was made in order to fix the kidney in the proper position during this procedure. The needle drew off a quantity of pale, amber fluid, which emptied the sac. The abdominal wound was closed. Recovery followed, and for two weeks there was no sign of recurrence. At the end of this time the tumor was again noticeable. It was decided to expose the kidney by an incision in the loin. After the sac was emptied the ureter could be seen running in a tortuous course. There was no valve. The mechanical condition which had led to the hydronephrosis appeared to be a twisting of the ureter at some point in its tortuous course. In order to efface as far as possible all of the abnormal twists in the ureter a gum-elastic bougie, about No. 6 of the French scale, was introduced with some difficulty through the ureter until it reached the neighborhood of the bladder. The sac was sewed to the edges of the wound, and a drainage-tube introduced into the pelvis of the kidney. The bougie was left *in situ*. The recovery, although slow, was uneventful. The bougie was removed at the end of three and one-half days, and the drainage-tube at the end of nineteen days.

The author calls attention to two interesting points in the success of the case: first, the considerable degree of activity retained by a kidney so long affected by a very great dilatation, which was shown by the quantity and quality of the urine obtained through the loin; secondly, the success which attended the treatment of the ureter. The restoration of permeability of the canal, which was accomplished by the bougie and assisted by the fixation of the sac in the loin, seems to have endured for a sufficient time since operation (seven months) to lead to the hope that it may prove permanent.

Tuffier is reported as having cured nine cases of intermittent hydronephrosis by fixation of the movable kidney in its normal position. The action of the bougie is explained as removing the various curves of the ureter while the pelvis is contracting and pulling it into shape. In addition, a moderate amount of inflammation is set up in the walls of the ureter which stiffens it and attaches it to the adjacent parts, which tends to retain its natural position.

Fashion in Antiseptics.—DUNN (*Med. Press and Circular*, May 5, 1897) points out the fact that although the antiseptics used at present produce gratifying and satisfactory results, they all have their disadvantages, and none of them are universally applicable. The fashion in antiseptics changes and should change until the surgeon meets with the ideal antiseptic. This the author describes as one which could be used in its various forms for every purpose, effectually, perfectly, and without causing in any way deleterious effects either to the surgeon or the patient.

The results obtained by Röhrer, Kossmann, Bimmermann, Ostermann, and others, in extended trials with the antiseptic chinosol led the author to test its properties, and the result has been very gratifying. The claims for the drug are that it is: (1) non-caustic; (2) non-toxic; (3) very diffusible; (4) a powerful deodorizer; (5) non-hygroscopic; and (6) that it does not coagulate albumin. The author's experience with it justifies these claims. Its great advantage, he thinks, is that it can be used for everything as an antiseptic. It meets the difficulty of strong solutions of carbolic acid, because it does not injure the skin of the hands; in a double sense it is superior to the perchloride, because (1) it does not harm the instruments, and (2) does not coagulate albumin. It is a perfect antiseptic powder and combines with boric acid. It is a powerful antiseptic, destroying virulent germs in 1 to 10,000 solutions.

A New Operation for Extroversion of the Bladder.—HARRISON (*Medical Press and Circular*, April 28, 1897) describes an operation which he employed for the relief of a distressing condition resulting from an extroversion of the bladder in a boy fifteen years of age. The patient's thighs and body were excoriated by the urine, while the surface of the exposed bladder-wall was tender and liable to bleed on the slightest touch.

The first step was the removal of the left kidney by nephrectomy. After a lapse of eleven months, when the patient had fully recovered from this operation, a bougie was inserted into the remaining ureter; it was then found by dissection through the lumbar region at the level of the iliac crest. After ligation it was resected and the proximal end brought out through and stitched to the edge of the wound.

The urine now flowed out at this point, and the exposed mucous surface of the bladder was dressed with an antiseptic sedative ointment. It was noted that during the transplanting of the ureter retching and attempts to vomit became continuous. The patient also vomited at frequent intervals for twenty-four hours, when the vomiting ceased after the removal of the suture which united the ureter to the wound. The change in the mode of urination was of great benefit to the patient. The urine was of a different character, and did not excoriate as it did after passing over the exposed mucous surface of the bladder. His general condition was also much improved.

OTOLOGY.

UNDER THE CHARGE OF

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Foreign Bodies in the Ear.—PREOBRASHENSKY thus summarizes the teachings of the literature on the subject of foreign bodies in the ear (*Wiener klin. Rundschau*, 1896, Nos. 33–36): 1. An unskilled person should never attempt the instrumental extraction of a foreign body. 2. Foreign bodies reach the middle ear almost exclusively as the result of inexperienced attempts at extraction. 3. The foreign body usually does less harm than endeavors at its extraction by an inexperienced hand. 4. The changes produced by the presence of a foreign body in the ear cannot be estimated by the length of time it has lodged there. 5. The injection of warm water is an infallible means of securing the evacuation of any foreign body from the ear. Irrigation with alcohol will prevent swelling of vegetable matter. [The ear may be syringed with alcohol instead of water, in some cases, in order to prevent swelling of a vegetable substance.—Rep.]. 6. There is no indication for hasty removal of foreign bodies which give rise to no troublesome symptoms. 7. The inflammation caused by necrosis from unskilled attempts at extraction may be met by expectant treatment as long as no dangerous symptoms are present. 8. The choice of an operation depends mainly on the condition of the external auditory meatus. As to living objects, insects are easily killed by water or oil, and may then be washed away, the only exception being larvæ, which are rendered more lively by water, and cling too firmly to the tissues of the ear to be syringed from their position. [A drop or two of chloroform or ether will promptly kill larvæ in the ear. They can then be removed by forceps, but only by an expert.—Rep.]

Facial Paralysis of Otitic Origin.—A. CARTAZ points out two ways in which facial palsy may be produced by inflammation in the drum-cavity (*Archives Internationales de Laryngology*, 1896). The first cause named is compression of the nerve, by exudation, hyperæmia, or swelling of the mucous membrane in the tympanic space. The second is by neuritis by infection from the inflammation in the drum, and is the more frequent cause of facial palsy. He presents two illustrative cases; the palsy in the cases due to compression being promptly relieved by paracentesis of the membrana and an